Central Greene School District

WCES Fax 724-852-1160
MBM Fax 724-627-0637
WCHS Fax 724-852-2090

AUTHORIZATION FOR MEDICATIONS TO BE TAKEN DURING SCHOOL HOURS

The following section is to be completed by the **PARENT:**

Child's Name	Sex	Date of Birth

Physician's Name	Telephone Number

I request that my child be assisted in taking the medicine(s) described below at school by authorized persons or permitted to medicate himself/herself as also authorized by me and my physician (see below).

Date	Parent/Guardian Signature	Home phone	Emergency Phone

The following section is to be completed by the **PHYSICIAN:**

Diagnosis for which medication is given: _____

Name of Medicine:
Form:
Dose:
If medication is to be given **DAILY,** at what time?
If medication is to be given "**WHEN NEEDED**", Describe indications:
How soon can it be repeated:
Is child authorized to medicate himself/herself?
List significant side effects:
Length of time this treatment is recommended:

Other information: _____

Date: _____ Physician's signature _____